SERFF Tracking Number:	*ALST-127084670*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*48277*
Company Tracking Number:	*GVDIC RIDERS*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Disability Insurance Riders*		
Project Name/Number:	*/*		

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Group Disability Insurance Riders	SERFF Tr Num: ALST-127084670	State: Arkansas
TOI: H11G Group Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num: 48277
Sub-TOI: H11G.002 Short Term	Co Tr Num: GVDIC RIDERS	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Angie Redden, Jennifer Aiello, Lynn Bautista, Patti Hicks, Sara Welch	Disposition Date: 03/18/2011
	Date Submitted: 03/18/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer, Association, Trust, Other	Explanation for Other Group Market Type: Unions
Overall Rate Impact:	Filing Status Changed: 03/18/2011
	State Status Changed: 03/18/2011
Deemer Date:	Created By: Sara Welch
Submitted By: Sara Welch	Corresponding Filing Tracking Number:

Filing Description:

RE: Group Disability Insurance Rider Forms FMDR1, et al, as listed on the attached List of Forms

NAIC Number: 60534

FEIN Number: 59-0781901

The above referenced forms are being submitted for your review and approval. These forms are new and do not

SERFF Tracking Number:	*ALST-127084670*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*48277*
Company Tracking Number:	*GVDIC RIDERS*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Disability Insurance Riders*		
Project Name/Number:	*/*		

replace any forms previously approved by your department. These products are solicited by agents licensed to do business within your state and will be marketed to approved groups.

Forms FMDR1; IBDR1; OARDR1; and SADR1 will be used with our Group Disability Certificate of Insurance, GVDIC. The Certificate of Insurance was filed and approved on 2/2/2011 under SERFF filing number ALST-126989580 (state tracking number 47778).

Also included in this filing are previously approved rider(s) which have been filed for use with some of our other group products and may also be attached to the Group Disability Certificate mentioned above. GCCDSL was filed and approved on 6/2/2010 under filing number ALST-126642407. GCROPR was filed and approved on 6/2/2010 under filing number ALST-126643986.

Material may vary, but will always be in accordance with your state laws. A Statement of Variability is enclosed, which outlines the variables for the submitted forms. Any logo, officer signature, or Home Office address and telephone number that appears on these forms is subject to change.

If you have any questions regarding this filing, feel free to contact me at jhop4@allstate.com, or (904) 992-2541. Thank you for your continued consideration.

Sincerely,

Jennifer R. Aiello, ALMI, ACS, AIRC

Company and Contact

Filing Contact Information

Jennifer Aiello, Filing Analyst
Attn: Legal/Compliance
1776 American Heritage Life Drive
Jacksonville, FL 32224-9983

jhop4@allstate.com
904-992-2541 [Phone]
904-992-2975 [FAX]

Filing Company Information

American Heritage Life Insurance Company
ATTN: Legal/Compliance
1776 American Heritage Life Drive
Jacksonville, FL 32224-9983
(904) 992-1776 ext. [Phone]

CoCode: 60534
Group Code: 8
Group Name: Allstate
FEIN Number: 59-0781901

State of Domicile: Florida
Company Type: Life and Health
State ID Number:

SERFF Tracking Number:	*ALST-127084670*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*48277*
Company Tracking Number:	*GVDIC RIDERS*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Disability Insurance Riders*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$200.00
Retaliatory?	No
Fee Explanation:	$50.00 per rider X 4 riders = $200.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	$200.00	03/18/2011	45741588

SERFF Tracking Number:	*ALST-127084670*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*48277*
Company Tracking Number:	*GVDIC RIDERS*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Disability Insurance Riders*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/18/2011	03/18/2011

SERFF Tracking Number:	*ALST-127084670*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*48277*
Company Tracking Number:	*GVDIC RIDERS*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Disability Insurance Riders*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 03/18/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ALST-127084670*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*48277*
Company Tracking Number:	*GVDIC RIDERS*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Disability Insurance Riders*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	List of Forms Being Filed	Approved-Closed	Yes
Supporting Document	Previously Approved GCCDSL and GCROPR	Approved-Closed	Yes
Form	Family Medical Leave and Doula Services Rider	Approved-Closed	Yes
Form	Increasing Benefit Period Rider	Approved-Closed	Yes
Form	On the Job Accident Disability Rider	Approved-Closed	Yes
Form	Survivor and Accident Rider	Approved-Closed	Yes

SERFF Tracking Number:	*ALST-127084670*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*48277*
Company Tracking Number:	*GVDIC RIDERS*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Disability Insurance Riders*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: FMDR1

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/18/2011	FMDR1	Certificate Amendment, Insert Page, Endorsement or Rider	Family Medical Leave and Doula Services Rider	Initial		64.600	FMDR1.pdf
Approved-Closed 03/18/2011	IBDR1	Certificate Amendment, Insert Page, Endorsement or Rider	Increasing Benefit Period Rider	Initial		58.600	IBDR1.pdf
Approved-Closed 03/18/2011	OADR1	Certificate Amendment, Insert Page, Endorsement or Rider	On the Job Accident Disability Rider	Initial		51.800	OADR1.pdf
Approved-Closed 03/18/2011	SADR1	Certificate Amendment, Insert Page, Endorsement or Rider	Survivor and Accident Rider	Initial		53.700	SADR1.pdf

AMERICAN HERITAGE LIFE INSURANCE COMPANY

[1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687]

FAMILY MEDICAL LEAVE AND DOULA SERVICES RIDER

This rider is issued in consideration of the rider premium and your request for this rider. Benefits are subject to all of the terms, conditions and provisions of the certificate. All terms defined and used in the certificate apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Certificate. The certificate to which this rider is attached.

Certified Doula. A trained professional who provides support to women and their families during pregnancy, childbirth, and the period of time following the birth and is a member of a national doula association.

Family Medical Leave (Leave). Your leave of absence to provide full time care for a child, spouse or parent (family member) or for your own serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 (FMLA) and any amendments, or by applicable state law.

Rider Date. The effective date of coverage under this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our home office in accordance with our coverage dating rules in effect at the time this rider is issued.

BENEFIT INFORMATION

General Information for Family Medical Leave Benefit

We will pay the monthly Leave benefit if you meet all of the following conditions:

1. The rider date is at least **[**30**]** days prior to the date the leave starts;
2. Your coverage under the certificate and this rider are in effect at the start date of your leave;
3. You are an active employee on the date you begin your leave;
4. You are not eligible for or receiving disability benefits under your certificate or any rider attached to your certificate;
5. You are not working on a full time or part time basis during your leave;
6. Your leave has been approved by your employer as a leave qualifying within FMLA guidelines; and
7. Your leave extends for at least **[**7**]** consecutive days.

When your employer approves your request for a leave you must notify us. We may require written confirmation of your employer's approval of the leave.

Monthly Benefit Amount for Family Medical Leave Benefit

If you are on leave and all of the conditions listed in the General Information above are met we will pay the monthly benefit amount (or part of the monthly benefit amount, if less than a full month) listed **[**on the Certificate Specifications page**][**on page 3**][**in your benefit statement**]** for a covered leave at the end of the month for which it is due. The benefit is payable from the first day of your leave after you have been on leave for at least **[**7**]** consecutive days. You will receive benefits as long as you remain on leave up to a maximum of 12 weeks per calendar year.

If a benefit is payable for any period less than a full month, we pay 1/30th of the applicable monthly benefit for each day.

When a benefit is due for a payable claim, we will send you a payment up to the maximum of 12 weeks per calendar year.

You must notify us when your leave ends. We will stop sending payments and your claim will end on the earliest of the following:

1. The date your employer's approval of your leave ends;
2. The date you return to work on a full time or part time basis;
3. The date any requested proof of your employer's continued approval of your leave is not submitted;
4. The date you become eligible for disability benefits under the certificate or another rider attached to the certificate;
5. The end of the 12 week maximum benefit period; or
6. The date of your death.

BENEFIT INFORMATION (Continued)

Monthly Benefit Amount for Certified Doula Services

When you receive one of the services listed below from a Certified Doula, we pay the benefit amount listed **[**on the Certificate Specifications page**][**on page 3**][**in your benefit statement**]**. This benefit is limited to 1 payment per calendar year.

Covered Doula Services are:

- Antepartum (during pregnancy and labor prior to delivery)
- Childbirth (assistance with delivery)
- Postpartum (after childbirth)

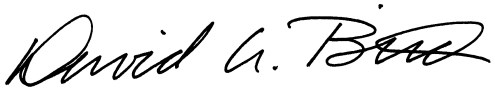
TERMINATION

This rider terminates at the earliest of:

1. the date the certificate is canceled;
2. the date the group policy is canceled;
3. the last day of the period for which any required premium payments were made;
4. the last day you are in active employment with your employer and/or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision;
5. the date you are no longer in an eligible class;
6. the date your class is no longer eligible; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this rider.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

Secretary



President

AMERICAN HERITAGE LIFE INSURANCE COMPANY

[1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687]

INCREASING BENEFIT PERIOD RIDER

This rider is issued in consideration of the rider premium and your request for this rider. Benefits are subject to all of the terms, conditions and provisions of the certificate. All terms defined and used in the certificate apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Certificate means the certificate to which this rider is attached.

Maximum Benefit Period means the maximum benefit period payable under your certificate.

Rider Anniversary means the first rider anniversary is one complete year after the rider date. Each subsequent rider anniversary occurs one complete year after the previous rider anniversary.

Rider Date means the effective date of coverage under this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our home office in accordance with our coverage dating rules in effect at the time this rider is issued.

BENEFIT INFORMATION

Increase to Maximum Benefit Period. On each rider anniversary listed **[**on the Certificate Specifications**][**on page 3A of your Certificate**][**in your benefit statement**]** the maximum benefit period increases as shown **[**on the Certificate Specifications**][**on page 3A of your Certificate**][**in your benefit statement**]**. If you are receiving benefits for a disability on a rider anniversary, the maximum benefit period for that disability will be the increased period listed for that rider anniversary.

TERMINATION

This rider terminates at the earliest of:

1. the date the certificate is canceled;
2. the date the group policy is canceled;
3. the last day of the period for which any required premium payments were made;
4. the last day you are in active employment with your employer and/or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the “Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence” provision;
5. the date you are no longer in an eligible class;
6. the date your class is no longer eligible; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this rider.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

Secretary

President

AMERICAN HERITAGE LIFE INSURANCE COMPANY

[1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687]

ON THE JOB ACCIDENT DISABILITY RIDER

This rider is issued in consideration of the rider premium and your request for this rider. Benefits are subject to all of the terms, conditions and provisions of the certificate. All terms defined and used in the certificate apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Certificate means the certificate to which this rider is attached.

[Deductible Sources of Income means the amount that you receive, or are eligible to receive, as disability income payments under any **[**individual**] [**or**] [**group**] [**disability income**]** insurance policies **[**which are paid for by your employer**] [**or other group insurance coverage**].]**

On The Job Injury means a bodily injury that occurs while you are at your place of work and that is the direct result of an accident and not related to any other cause. On the job injury which occurs before you are insured under this rider will be treated as a sickness. Disability must begin while you are insured under this rider.

Rider Date means the effective date of coverage under this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our home office in accordance with our coverage dating rules in effect at the time this rider is issued.

Totally Disabled means you are totally disabled when we determine that you are unable, due to an on the job injury, to perform the substantial and material duties of your own occupation. You must be under the regular care of a physician, unless the physician states that no further treatment is needed. You must also not be working in any job for wage or profit.

BENEFIT INFORMATION

General

The following are shown **[**on the Certificate Specifications page**][**on page 3**][**in your benefit statement**]** for this rider:

1. the elimination period(s);
2. the monthly benefit amount; and
3. the maximum benefit period.

You must be an active employee on the date your disability occurs for the benefits in this rider to be payable.

We may require an exam by a doctor, other medical practitioner, or vocational expert of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require an interview by our authorized representative.

The loss of a professional or occupational license or certification does not, in itself, constitute a disability.

Elimination Period

You must be totally disabled continuously throughout the elimination period.

If your covered disability is the result of an on the job injury that occurs while covered under this rider, **[**the elimination period is the time period stated**] [**on the Certificate Specifications page**][**on page 3**][**in your benefit statement**]] [**benefits begin immediately**].**

Monthly Benefit

We pay the monthly benefit (or part of the monthly benefit if less than a full month) for a covered disability at the end of the month for which it is due. You will receive benefits as long as you remain totally disabled, except we pay only up to the maximum benefit period for any one total disability.

If a monthly benefit is payable for any period less than a full month, we pay 1/30th of the applicable monthly benefit for each day.

Monthly Benefit (Continued)

When a benefit is due for a payable claim, we will send you a payment each month up to the maximum benefit period. The maximum benefit period during a continuous period of disability is shown **[**on the Certificate Specifications page**][**on page 3**][**in your benefit statement**]**.

We will stop sending payments and your claim will end on the earliest of the following:
1. when you are able to return to work in your own occupation on a part-time or full-time basis but choose not to do so; or
2. the end of the maximum benefit period; or
3. the date you are no longer disabled under the terms of this rider; or
4. the date proof of your continuing disability is not submitted; or
5. the date of your death.

Amount of Payment

When you are totally disabled and not working we will follow the process described below to determine your amount of payment:
1. Multiply your monthly earnings by **[**60%**]**.
2. **[**Subtract any deductible sources of income from item 1.**]**
3. Determine the lesser of the amount listed **[**on the Certificate Specifications page**][**on page 3**][**in your benefit statement**]** and the result of item**[**2**]**.
4. Compare item **[**3**]** with the **[**$100**]** minimum monthly payment and we will pay the greater of the two.

The amount calculated in item 4 is your monthly payment.

After the elimination period, if you continue to be disabled for less than 1 month, we will send 1/30th of your payment for each day of disability.

[We may apply this amount toward an outstanding overpayment.**]**

Monthly Benefit Reduction for Workers' Compensation. For any month you receive any workers' compensation disability or other state disability benefits while entitled to a disability benefit under this rider, the monthly benefit we pay you for that total disability is reduced to 50% of the monthly benefit amount listed **[**on the Certifications Specifications page**][**on page 3**][**in your benefit statement**]**.

We have the right to require reasonable proof of any such disability benefit you receive during any month.

Concurrent Disability

During any period in which you are disabled due to more than one cause, benefits will be paid as if you are disabled due to only one cause. In no event will being disabled due to more than one cause extend the time for which benefits will be paid under the maximum benefit period.

Recurrent Disability

If you have a recurrent disability, we will treat the disability as part of the prior claim and another elimination period will not have to be completed if you were continuously insured under this rider for the period between the prior claim and the recurrent disability and:
1. your recurrent disability occurs within **[**6 months**]** of the end of your prior claim; or
2. you fully performed any occupation for your employer on a part-time or full-time basis for less than **[**30 full days**]** and your current disability is unrelated to your prior disability for which we made a payment.

Your recurrent disability will be subject to the same terms as your prior claim.

Any disability which occurs after **[**6 months**]** from the date your prior claim ended will be treated as a new claim. Your new claim will be subject to all of the provisions of this rider.

As used in this provision, recurrent disability means a disability which is:
1. caused by a worsening in condition; or
2. due to the same cause(s) or related cause(s) as the prior disability for which we made a payment.

As used in the provision, any occupation means any gainful occupation for which you are suited by education, training or experience.

BENEFIT INFORMATION (Continued)

[Waiver of Premium

After you have been totally disabled as the result of an on the job injury for **[**30**]** or more consecutive days while covered under this rider, or after the elimination period shown **[**on the Certificate Specifications page**][**on page 3**][**in your benefit statement**]**, whichever is greater, we will waive the premium for your coverage including this and any other attached rider(s) for as long as you remain disabled.

This benefit will end at the earlier of the date your disability ends or the date you have reached the maximum benefit period shown **[**on the Certificate Specifications page**][**on page 3**][**in your benefit statement**]**. You must pay all premiums to keep your coverage including this and any other attached rider(s) in force until you have qualified for waiver of premium as described in this provision.

You must send us written notice as soon as you are no longer disabled. We will assume that you are no longer disabled if you:
1. do not send us satisfactory proof of loss when we request it; or
2. notify us that you are no longer disabled.

You must pay all premiums to keep your coverage and any attached rider(s) in force beginning with the first premium due after you are no longer disabled.

Waiver of premium does not apply to any period that you are totally disabled as a result of an on the job injury which is excluded by name or specific description.

There is no limit to the number of times that you can receive this waiver of premium benefit.**]**

LIMITATIONS AND EXCLUSIONS

[Pre-Existing Conditions. The pre-existing condition limitation described in your certificate applies to this rider.]

Exclusions. The exclusions listed in your certificate apply to this rider.

TERMINATION

This rider terminates at the earliest of:
1. the date the certificate is canceled;
2. the date the group policy is canceled;
3. the last day of the period for which any required premium payments were made;
4. the last day you are in active employment with your employer and/or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the “Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence” provision;
5. the date you are no longer in an eligible class;
6. the date your class is no longer eligible; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this rider.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

Secretary

President

AMERICAN HERITAGE LIFE INSURANCE COMPANY

[1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687]

SURVIVOR AND ACCIDENT RIDER

This rider is issued in consideration of the rider premium and your request for this rider. Benefits are subject to all of the terms, conditions and provisions of the certificate. All terms defined and used in the certificate apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Accident means the unforeseen occurrence of an event which results in injury.

Allstate Auto Insurance Policy means a policy of insurance that provides coverage for your automobile with an insurance company that is a subsidiary of The Allstate Corporation authorized to provide automobile insurance coverage.

Certificate means the certificate to which this rider is attached.

Personal Vehicle means a land motor vehicle designed for use principally on public roads.

Rider Date means the effective date of coverage under this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our home office in accordance with our coverage dating rules in effect at the time this rider is issued.

BENEFIT INFORMATION

Survivor Sickness Death Benefit. If you die while receiving benefits under the certificate for a disability caused by a sickness we pay the amount listed **[**on under the Certificate Specifications**][**on page 3**][**in your benefit statement**]**. This benefit is not payable if we pay a benefit under the Survivor Accidental Death Benefit. This benefit will be paid to your designated beneficiary or to your estate if a beneficiary is not named.

Survivor Accidental Death Benefit. If you die due to an accident we pay the amount listed **[**on the Certificate Specifications**][**on page 3**][**in your benefit statement**]**. The date of death must be within 180 days of the date the accident occurs. This benefit is not payable if we pay a benefit under the Survivor Sickness Benefit. This benefit will be paid to your designated beneficiary or to your estate if a beneficiary is not named.

Allstate Auto Benefit. If you receive a benefit under the certificate for a disability caused by an accident while driving or riding in a personal vehicle and were at the time of the accident insured under an Allstate auto insurance policy, we pay the amount listed **[**on the Certificate Specifications**][**on page 3**][**in your benefit statement**]**. The disability must begin within 180 days of the date the accident occurs. This benefit is paid once per disability. We may require proof of your insurance under an Allstate auto insurance policy.

LIMITATIONS AND EXCLUSIONS

[Pre-Existing Conditions. The pre-existing condition limitation described in your certificate applies to this rider.]

Exclusions. The exclusions listed in your certificate apply to this rider.

TERMINATION

This rider terminates at the earliest of:

1. the date the certificate is canceled;
2. the date the group policy is canceled;
3. the last day of the period for which any required premium payments were made;
4. the last day you are in active employment with your employer and/or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision;
5. the date you are no longer in an eligible class;
6. the date your class is no longer eligible; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this rider.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

Secretary

President

SERFF Tracking Number:	*ALST-127084670*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*48277*
Company Tracking Number:	*GVDIC RIDERS*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Disability Insurance Riders*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	03/18/2011

Comments:

Attachment:

AR Readability Certification.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	03/18/2011

Comments:

We have attached ABJ4520AR which will be used to enroll in GVDIC, Group Disability Insurance. This form was approved by your department on 2/14/2011 under SERFF filing number ALST-126989580 (state tracking number 47778).

Attachment:

ABJ4520AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	03/18/2011

Comments:

Attachment:

GVDI Riders Statement of Variability.pdf

		Item Status:	Status Date:
Satisfied - Item:	List of Forms Being Filed	Approved-Closed	03/18/2011

Comments:

Attachment:

AR List of Forms.pdf

		Item Status:	Status

SERFF Tracking Number:	*ALST-127084670*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*48277*
Company Tracking Number:	*GVDIC RIDERS*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Disability Insurance Riders*		
Project Name/Number:	*/*		

Satisfied - Item:	Previously Approved GCCDSL and GCROPR	Approved-Closed	**Date:** 03/18/2011

Comments:

Attachments:

GCCDSL.pdf

GCROPR.pdf

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6687

To the Policy Review Section, Arkansas Department of Insurance.

I certify that I have carefully reviewed the form(s) listed below and to the best of my knowledge and ability, find that the form(s) meet the minimum reading ease score on the test used.

Form	Score
FMDR1	64.6
IBDR1	58.6
OADR1	51.8
SADR1	53.7

Date: March 14, 2011

Diane D. Ierna

Diane Ierna
Assistant Vice President, Compliance Department

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate Benefits

[For AHL Home Office use only

Group No.	Account	Location

Dep Code	Smoker	Issue State
E S C F	EE Y or N SP Y or N	

EFFECTIVE DATE]

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Group Voluntary Disability

☐ New Certificate ☐ Change/Increase Certificate # _____

Remarks:	This box for AHL Home Office use only

[GENERAL INFORMATION SECTION

Please print with black ink

(Please complete entire section)

EMPLOYEE'S NAME Last (Sr, Jr, etc.) First M.I.	☐ M ☐ F	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
RESIDENT ADDRESS (Street or P.O. Box)	CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	RESIDENT PHONE NUMBER	EMPLOYER/ASSOCIATION/UNION	DATE HIRED (MM/DD/YEAR)
OCCUPATION	PLANT OR DIVISION		
EMPLOYEE'S EMAIL	BENEFICIARY'S NAME (Last, First, M.I.)	RELATIONSHIP	

Are you actively at work now and have you worked at least [20] hours each week performing all duties at your regular occupation at your regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? ☐ Yes ☐ No

If not, why? _____]

[DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Dependent's Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number
				]

[Short-Term Disability ☐ Yes ☐ No	Monthly Salary $_____	Elimination Period _____ Days Acc. _____ Days Sick.	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	Home Office Use Only SET ID/PLAN ID ACTIV/STD _____ and/or EMPLR/STD _____ and/or (other) _____
	Monthly Benefit $_____	Benefit Period _____ Months			

Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider
Rider Units							]

A. [Is this insurance to replace any existing disability coverage? ☐ Yes ☐ No

If yes, provide the Company Name: _____

B. Is there any other disability insurance in force or applied for that will continue after the effective date of this coverage? ☐ Yes ☐ No

If yes, complete the following:

Company Name: _____ Year Issued: _____

Monthly Benefit: _____ Elimination Period: _____ Benefit Period: _____]

[Premium/Billing Mode ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other Date of First Deduction _____ Requested Issue Date _____	Case Number	Producer/ Agent Number	Percentage Credit
	Employee ID		
	Situs State		]

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

[EVIDENCE OF INSURABILITY SECTION

If questions 1-3 are answered "Yes", please list the required health history in question 5. Use the additional space below for further explanation.

1.	Are you now being treated, or ever been treated or diagnosed, by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or have you ever tested positive for antigens or antibodies to an AIDS virus?	☐ Yes ☐ No
2a.	Have you in the last 2 years, had, been treated for, or been told by a member of the medical profession that you have: diabetes, emphysema, epilepsy, hepatitis, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's Disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, or pancreas; paralysis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke?	☐ Yes ☐ No
2b.	Have you in the last 2 years, had, or been treated for asthma, a mental or nervous illness, or any disorder of the back or neck?	☐ Yes ☐ No
2c.	Have you in the last year had either: (1) a systolic blood pressure reading higher than 150 more than once; or (2) a diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No
2d.	Have you in the last 2 years been treated for or counseled for alcohol or drug abuse?	☐ Yes ☐ No
2e.	Have you had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time?	☐ Yes ☐ No
3.	Have you, in the last 3 years, had your driver's license suspended or revoked or been arrested for reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents?	☐ Yes ☐ No

4.	Please indicate height and weight	Employee Height: Weight:

5. Nature of Illness/Injury or Medical Attention/ Reason Last Consulted | Date and/or Duration | Name and Address of Physician or Hospital/Clinic

_____

_____ **]**

Use this space for any additional explanation of questions 1-[3] above. Indicate the applicable question number. Use additional paper if needed.

[ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy ("my Certificate"), and all future correspondence regarding my Certificate, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and certificate administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Certificate and correspondence regarding my Certificate via the following address: **[**www.allstateatwork.com/mybenefits**]**.

My consent is valid while I am covered under the group policy. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my Certificate, free of charge, by calling, toll-free: **[**1-800-521-3535**]**; or by writing to: **[**Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224**]**.

☐ YES, I agree to receive my Certificate and all correspondence regarding my Certificate electronically via the internet.
☐ NO, I prefer to receive paper copies of my Certificate and all correspondence regarding my Certificate.**]**

CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this evidence of insurability. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this form is signed. · **I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee's Signature _____ Signed at _____ Date Signed _____
(City and State)

American Heritage Life Insurance Company (AHL)

Explanation of Variable Language for Group Riders FMDR1, IBDR1, OADR1 and SADR1

These riders will be available to issue with approved group policies to employer groups, labor union groups, associations and Trusts. The following explains the variables included in the forms. The headings correspond to the sections within the rider forms. When deleted text creates blank spaces, the following text may be moved to another page with the same form number.

Family Medical Leave and Doula Services Benefit Rider FMDR1

Address: The current address will be on all riders issued.

General Information for Family Medical Leave Benefit:
The number of days in Item 1 will usually be 30 days but may be 15 or 45 days if agreed to by us and the policyholder.

The number of day in Item 7 will usually be 7 but may be 14 or 30 days if agreed to by us and the policyholder.

Monthly Benefit Amount for Family Medical Leave: Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.

The waiting period will usually be 7 days but may be 14 or 30 days if agreed to by us and the policyholder.

Monthly Benefit Amount for Certified Doula Services: Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

Officer Signatures: The signatures will reflect the current Secretary and President on all riders issued.

Increasing Benefit Period Rider IBDR1

Address: The current address will be on all riders issued.

Increase to Maximum Benefit Period. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.

Officer Signatures: The signatures will reflect the current Secretary and President on all riders issued.

On the Job Accident Disability Rider OADR1

Address: The current address will be on all riders issued.

Definitions: The Deductible Sources of Income may be deleted entirely if agreed to by us and the policyholder.
We may only deduct for individual or group disability insurance, only when paid for by the employer or for any other group insurance providing disability benefits or in combination if agreed to by us and the policyholder.

Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.

On the Job Accident Disability Rider OADR1 (Continued)

Benefit Information:

General. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

Elimination Period. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.

Monthly Benefit. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

Amount of Payment. The percentage will usually be 60% but may be any percentage between 10 and 80.

We may or may not subtract deductible sources of income.

Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

Item numbers will be renumbered if any are omitted.

The minimum monthly payment will usually be $100 but may be any multiple of $100 between $100 and $500 if agreed to by us and the policyholder.

We will usually reserve the right to apply the benefit to outstanding overpayments but may remove this right if agreed to by us and the policyholder.

Monthly Benefit Reduction for Worker's Compensation. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

Recurrent Disability. The timeframe indicated for recurrent disabilities will usually be 6 months, but may be between 3 to 12 months as agreed to by us and the policyholder.

Performance of an occupation will usually be limited to 30 days, but may be between 1 to 90 days if agreed to by us and the policyholder.

Waiver of Premium. The Waiver of Premium provision may be deleted in its entirety if agreed to by us and the policyholder. The number of days will usually be 30 but may be 60 or 90 if agreed to by us and the policyholder.

Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.

Pre-Existing Conditions. This may be deleted if agreed to by us and the policyholder.

Officer Signatures: The signatures will reflect the current Secretary and President on all riders issued.

Survivor and Accident Rider SADR1

Address: The current address will be on all riders issued.

Benefit Information. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.

Pre-Existing Conditions. This may be deleted if agreed to by us and the policyholder.

Officer Signatures: The signatures will reflect the current Secretary and President on all riders issued.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6687

Form	Description
FMDR1	Family Medical Leave Benefit Rider
IBDR1	Increasing Benefit Period Rider
OADR1	On-the-Job Accident Rider
SADR1	Survivor and Accident Rider

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224

CONTINUATION OF COVERAGE DURING A STRIKE OR LAYOFF RIDER

This rider is issued in consideration of the rider premium and the enrollment form for this rider. Benefits are subject to the provisions of this rider and the certificate it is attached to. All terms defined in the certificate and used in this rider apply to this rider, unless otherwise defined in this rider.

DEFINITIONS

Certificate. The certificate to which this rider is attached.

Layoff. Means the dismissal of an employee from his or her job by an employer because of business reasons, such as the decision that certain positions are no longer necessary or tightened budgetary constraints or work shortage (not due to poor performance or misconduct).

Rider Date. Means the effective date of coverage under this rider. The rider date is the certificate date.

Strike. Means work stoppage caused by the refusal of unionized employees to perform work in order to force an employer to comply with demands. The strike must be between your union and your employer and supported and/or sponsored by your national union headquarters.

BENEFITS

This rider provides for a continuation of coverage for all insureds during a strike or layoff. We will waive the current month's premium and continue coverage for the certificate and all riders attached to the certificate if you, the insured employee or member, have not worked due to strike or layoff for at least 14 of the 30 days prior to your premium due date while coverage under the policy is in force.

Strike. Premiums will be waived and coverage will continue for up to a period of 6 months during a strike. Coverage under this benefit will cease automatically at the end of the 6 month period if the strike is still in effect on such date.

If the strike ends before the end of the 6 month period, premium payment is to be resumed on the day after the strike ends.

Recurrent Strike. If you return to work after a strike and then stop working again due to a strike in less than 30 days, this will be considered the same strike for purposes of calculating the 6 month benefit for a strike.

The strike must be confirmed by your union or employer on a monthly basis. You are responsible for providing us with the appropriate contact information for your union.

Layoff. Premiums will be waived and coverage will continue if you are laid off while your certificate is in force.

1. Premiums will be waived for a period of up to 6 months. We will not waive the premiums if the layoff is a result of:
   a. voluntary termination of your job; or
   b. retirement; or
   c. termination of your job because of performance reasons such as performance deficiencies, attendance problems or unacceptable behavior; or
   d. routine, regularly-scheduled or seasonal shutdowns.
2. Coverage under this benefit will cease automatically at the earliest of the following:
   a. the monthly certificate date that coincides with or next follows the date you are re-employed by the employer, or employed by a new employer; or
   b. the date you refuse to give us written proof of your continuing layoff, if we ask for it.

Recurrent Layoff. If you return to work after a layoff and then stop working again due to a layoff in less than 30 days, this will be considered the same layoff for purposes of calculating the 6 month benefit for a layoff.

You must obtain written confirmation from your employer that you were subject to a layoff.

Premiums will not be waived for you if your coverage under the certificate or this rider terminated due to your failure to make required premium payments.

Disability During a Strike or Layoff. If you, the insured employee or member, are disabled and premiums are already being waived under a waiver of premium benefit of the policy, if applicable, you are not eligible for continuation of coverage under this rider.

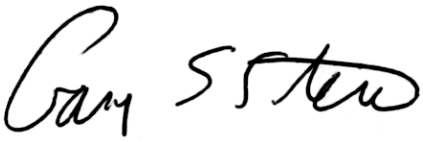
TERMINATION

This rider will terminate on the earliest of the following events:

1. the date the certificate is canceled; or
2. the date the group policy is canceled; or
3. the last day of the period for which any required premium payments were made; or
4. the last day you are in active employment or membership, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision; or
5. the date you are no longer in an eligible class; or
6. the date your class is no longer eligible.

Benefits under this rider are not eligible under the Continuation of Insurance (COBRA) provision under the policy.

Signed for American Heritage Life Insurance Company at its Home Office.



Secretary

President

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224

RETURN OF PREMIUM BENEFIT RIDER

This rider is issued in consideration of the enrollment form for this rider. Benefits are subject to the provisions of this rider and the certificate it is attached to. All terms defined in the certificate and used in this rider apply to this rider, unless otherwise defined in this rider.

DEFINITIONS

Certificate. The certificate to which this rider is attached.

Claim Incurred. Any claim incurred on the certificate or any riders that are or have been attached to the certificate, excluding any claims incurred before the rider date. A claim is considered incurred on the date an event for which we pay benefits occurs.

Layoff. Means the dismissal of an employee from his or her job by an employer because of business reasons, such as the decision that certain positions are no longer necessary or tightened budgetary constraints or work shortage (not due to poor performance or misconduct).

Rider Date. Means the effective date of coverage under this rider. The rider date is the certificate date.

Total Premiums Paid. The total premiums paid to us for the certificate and all riders that are or have been attached to the certificate, excluding any premiums which became due before the rider date and any unearned premiums refunded to you.

BENEFITS

This rider provides for a return of premium as a result of a layoff. We will return the total premiums paid for the certificate and all riders attached to the certificate if you lose your job due to layoff during the first 6 months while coverage under the policy is in force provided there has been no claim incurred.

Upon such return of the premiums, the certificate and all riders attached to the certificate will be void as of the effective date.

We will not return premiums if the layoff is a result of:

1. voluntary termination of your job; or
2. retirement; or
3. termination of your job because of performance reasons such as performance deficiencies, attendance problems or unacceptable behavior; or
4. routine, regularly-scheduled or seasonal shutdowns.

Premiums will not be refunded to you if your coverage under the certificate or this rider terminated due to your failure to make required premium payments.

You must obtain written confirmation from your employer that you were subject to a layoff to receive a refund of premiums.

TERMINATION

This rider terminates at the earliest of:

1. the date the certificate is canceled; or
2. the date the group policy is canceled; or
3. the last day of the period for which any required premium payments were made; or
4. the last day you are in active employment, except as provided under the “Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence” provision; or
5. the date you are no longer in an eligible class; or
6. the date your class is no longer eligible; or
7. the date a claim is incurred and becomes payable under the policy; or
8. 6 months after this rider is issued.

Benefits under this rider are not eligible under the Continuation of Insurance (COBRA) provision under the policy.

Signed for American Heritage Life Insurance Company at its Home Office.

Secretary

President

GCROPR